Park Central
OBSTETRICS & GYNECOLOGY *Associates*

NAME: _____ DATE: _____

HOME PHONE: _____

WORK PHONE: _____ DOB: _____

CELL PHONE: _____ AGE: _____

**PATIENT MEDICAL UPDATE**

List all medications you are presently taking including hormones or birth control pills:

_____

_____

Do you … Smoke Y/N How much? _____ Consume alcohol? Y/N _____

List any allergies to medications you may have:

_____

Form of contraception you are currently using:

_____ Hysterectomy _____ Ablation _____ Tubal Ligation _____ IUD

_____ Depo Provera _____ Birth Control Pill _____ Other _____

**QUESTIONS REGARDING YOUR PERIODS:**

First day of last period: _____ Length of Period: _____

Do your periods…

| | | |
|---|---|---|
| -Last longer or seem heavier than normal? | Y | N |
| -Affect your daily activities? | Y | N |
| -Require extra or double protection for normal activity | Y | N |
| -Prior to hormone/contraceptive therapy, were your periods heavy? | Y | N |

Surgery since last visit: Y/N _____

Have there been any changes in your family medical history? If yes, please explain:

_____

_____

Other pertinent medical issues or concerns:

_____

_____

Primary Care Physician Y/N If yes, please give name: _____

Phone: _____ Fax: _____

Modified 2/09 jaw